State of California Department of Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

**LICENSING PROGRAM**
**1426 Howe Avenue, Suite 54**
**Sacramento, CA 95825-3236**
**(916) 263-2382**
www.caldocinfo.ca.gov

## *APPLICATION FOR A DUPLICATE FICTITIOUS NAME PERMIT*

***(Fee - $30)***

***Please print or type.***

***Illegible applications will be returned.***

**FOR OFFICE USE ONLY**

**Fee Paid:**_____ **Receipt #:**_____

**Date Cashiered:**_____ **Cashier's Intl.:**_____

**Date Approved:**_____ **Date Denied:**_____

| | |
|---|---|
| **Owner / Co-owner (first, middle, last):** | |
| **Social Security Number/FEIN:** | |
| **Address:**<br>**Is this address currently on file with the Medical Board as your official address of record? If not, complete reverse.** | |
| **Telephone Number:**<br>**FAX Number (if applicable):** | **Telephone ( )**<br>**FAX ( )** |
| **Fictitious Name:** | |
| **Fictitious Name Permit Number:** | |

***Please provide all information requested below.***

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Request for Duplicate Permit:**<br>**(Check box to left of certificate requested.)** | ☐ | ☐ | **Duplicate Original Permit** | ☐ | **Duplicate Renewal Permit** | | |
| **Check all that apply:** | ☐ | **Lost** | ☐ | **Stolen** | ☐ | **Mutilated** | |
| | ☐ | **Destroyed** | ☐ | **Address Change** | ☐ | | |

**If you indicated lost, stolen, mutilated or destroyed, an explanation of the circumstances is required below (in the event your permit was mutilated, or you are requesting a duplicate due to name or address change, the original permit must be surrendered to our office along with this request).**

_____

_____

**I certify under penalty of perjury under the laws of the State of California that the information provided in this application, including any supporting documents, are true and correct and that I am licensed/registered to practice in the State of California.**

| | | |
|---|---|---|
| _____ | _____ | _____ |
| **Physician Signature** | **License Number** | **Date** |

**BOTH PAGES OF THIS FORM MUST BE COMPLETED.**

**Current Mailing Address**

_____

_____

_____

❒ **Check here if this is a change of address so your record can be updated.**

**NOTICE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to verify the identity of the licensee per Sections 118 and 2432 of the Business and Professions Code. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Licensing Program Chief is the custodian of records. Information provided in this application may be transferred to other governmental or law enforcement agencies.**

**Disclosure of your Social Security number (SSN) or Federal Employer Identification Number (FEIN) is mandatory. Section 30 of the Business and Professions Code and Public Law 94.455 (42 USCA 405(c)(2)(C) authorize collection of your SSN. Your SSN or FEIN will be used for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your SSN or FEIN, your application will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.**

## NOTARY

**This individual,_____, has appeared before me, signed in my presence and is identified as the above individual. Subscribed and sworn to before me this _____ day of _____, _____.**

_____

_____

**Notary Public Signature** **Telephone Number**

**Address**_____

**My commission expires _____.** **SEAL**